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SELF-DIRECTED DEATH, EUTHANASIA, AND THE TERMINATION OF LIFE-SUPPORT: REASONABLE DECISIONS TO DIE

G. STEVEN NEELEY†

If one death is accompanied by torture, and the other is simple and easy, why not snatch the latter?

It is not a question of dying earlier or later, but of dying well or ill. And dying well means escape from the danger of living ill.

—Seneca, *Ad Lucilium*

Epistulae Morales, Epistle 70

The law surrounding death and dying has failed to keep pace with medical technology.¹ Medical science has made it possible to sustain human existence past the point where the competent adult might rationally conclude that life is no longer worth living. Nevertheless, the current state of the law often makes it difficult, if not impossible, for the individual to exercise unfettered control over the act of dying.

The present dilemma results from a clash of ancient canons. While the common law has long recognized the right of the individual to be free from non-consensual invasions of bodily integrity and has generally extended this right to include the freedom to refuse necessary life-saving medical treatment,² the law has equally long been anathematic to suicide.³ Although suicide itself is no longer punishable and so is not strictly speaking a crime,⁴ attempted suicide is a crime in some states⁵ and twenty-six states

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1. Glenn W. Peterson, *Balancing the Right to Die with Competing Interests: A Socio—Legal Enigma*, 13 PEPP. L. REV. 109, 110 (1985).

2. Natanson v. Kline, 350 P.2d 1093 (Kan. 1960); Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914).

3. WAYNE R. LAFAVE AND AUSTIN W. SCOTT, JR., *HANDBOOK ON CRIMINAL LAW* § 7.8, at 649 (2d ed. 1986).

4. *Id.*

5. While no state criminalizes attempted suicide by statute, “[o]ne would presume that in states such as Alabama, Oregon and South Carolina, where the common law presumption against suicide has not been set aside, attempted

and the Commonwealth of Puerto Rico currently have laws which prohibit assisting a suicide.⁶ Moreover, the prevention of suicide has traditionally been identified by the courts and commentators as an important state interest that may limit a person's right to refuse life-saving medical treatment.⁷ This consideration is particularly troublesome in light of the fact that decisions to disemploy life-support are too easily swept under the same rubric. Indeed, the accepted legal definition of suicide includes: "[s]elf-destruction; the deliberate termination of one's own life;"⁸ "the act of self-destruction by a person sound in mind and capable of measuring his moral responsibility."⁹ Decisions to remove life-support are, specifically, intentional acts which are virtually certain to result in death. As an untoward result, situations have developed in which even seriously ill competent adults have found it nearly impossible to compel the removal of invasive life-support apparatus.¹⁰

Few courts have considered the underlying policy reason for the state interest in the prevention of suicide.¹¹ Those courts that have undertaken such an analysis "have hastily concluded that the policy behind preventing suicide is to avoid *irrational* self-destruction. They then reason that because the decision of a competent patient to forego treatment 'when death is inevitable and

suicide could be considered a crime as well.' H. Tristrom Engelhardt and Michele Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 SW. L. REV. 1003, 1018 n. 67 (1982). See also Catherine D. Shaffer, *Criminal Liability For Assisting Suicide*, 86 COLUM. L. REV. 348, 350 (1986). But see LA FAVE AND SCOTT, *supra* note 3, § 7.8 at 649.

6. Marzen, O'Dowd, Crone, and Balch, *Suicide: A Constitutional Right?* 24 DUQ. L. REV. 1, 98 (1985).

7. Satz v. Perlmutter, 362 So.2d 160 (Fla. Dist. Ct. App. 1978); *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Spring*, 405 N.E.2d 115 (Mass. 1980); Commissioner of Correction v. Meyers, 399 N.E.2d 452 (Mass. 1979); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); *In re Torres*, 357 N.W.2d 332 (Minn. 1984); *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

8. BLACK'S LAW DICTIONARY 1434 (6th ed. 1990).

9. WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY 1822 (2d. ed. 1990).

10. See, e.g., Bartling v. Superior Court, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); Bouvia v. Superior Court (Glencur), 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); Tune v. Walter Reed Army Medical Hosp., 602 F. Supp. 1452 (D.D.C. 1985); Satz v. Perlmutter, 362 So.2d 160 (Fla. Ct. App. 1978); *aff'd*, 379 So.2d 359 (Fla. 1980); *In re Lydia E. Hall Hosp.*, 455 N.Y.S.2d 706 (1982); *In re Farrel*, 529 A.2d 404 (N.J. 1987); State v. McAfee, 385 S.E.2d 651 (Ga. 1989); McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

11. Martha Alys Mathews, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CALIF. L. REV. 707, 736 (1987).

the treatment offers no hope of cure or preservation of life' is not irrational self-destruction, the states' interest in preventing suicide is not implicated. This superficial analysis leaves open the question whether a competent, nonterminal patients' refusal of treatment that could improve or stabilize her condition should be treated as a suicide."¹² The scenario is further complicated by the legal and psychiatric presumption that decisions to die constitute *prima facie* evidence of mental instability. O'Dea lamented in 1882 that "[t]he impression prevails, though not to its former extent, that suicide is, *per se*, proof of insanity: or, in other words, that whoever kills himself must necessarily be insane, at least at the moment of taking his life."¹³ More than a century later, Marzen, O'Dowd, Crone and Balch would still contend that "suicide is almost always a product of emotional or mental distress"¹⁴ and that "[t]he literature overwhelmingly supports the present presumption . . . that those who propose to or do commit suicide do so as the result of mental or emotional disorders or external pressures."¹⁵ But if the state intends to prevent all "irrational self-destruction"¹⁶ and the bare decision by an individual to hasten or bring about her own death is considered *per se* indicative of insanity then, arguably, no nonterminal adult patient who could "improve" or even "stabilize" her condition will be allowed to terminate artificial life-support or otherwise summon death.

The purpose of this paper is to challenge the common legal and psychiatric presumption that all decisions to die result from a clouded mind. Indeed, a realistic and common sense view of the issue asserts quite the contrary: namely, that self-directed death may prove to be an optimally rational course of action in light of an individual's circumstances and ends. While the state has a legitimate concern in the welfare of its citizens and should seek to prevent unwarranted loss of life, it should be loathe to force a mentally competent adult to remain alive against his will and best interests.

12. *Id.*

13. JAMES J. O'DEA, THE PHILOSOPHY OF SUICIDE, 257 (New York 1882).

14. Marzen et al., *supra* note 6, at 106.

15. *Id.* at 107.

16. George P. Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?* 22 U.C. DAVIS L. REV. 275, 381 (1989) (citing Robert M. Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 35 (1975)).

SUICIDE AND THE PRESUMPTION OF INSANITY

Roman law did not undertake a classification of suicides into sane and insane, nor did it make the question of sanity a material part of its legislation regarding suicide.¹⁷ The first trace of any such classification occurs in the Penitential of Theodore, Archbishop of Canterbury, where moral blame is roughly apportioned to the degree of sanity possessed by suicides at the time of death.¹⁸ Thus,

If anyone be so tormented by the devil as to run to and fro, scarce knowing what he does, and in that situation of mind should kill himself, it is proper to pray for such an one, provided he were previous to such possession a religious man. But, if he kill himself through despair, through any timidity, or from causes unknown, let us leave his judgment to God, and not dare to pray (say mass) for such an one. It is not lawful to say mass for one who hath voluntarily killed himself, but only to pray and bestow alms on his behalf. But some allow mass to be said for one who, impelled by a sudden temptation, seems to have murdered himself through an instantaneous distraction.¹⁹

In 673 the transmarine canons of the Catholic Church were adopted in England at the Council of Hereford under Theodore of Canterbury²⁰ and the attendant condemnation of suicide was formalized in 967 by the Saxon King Edgar.²¹ Edgar's law was "wholly ecclesiastical in character"²² and provided: "It is neither lawful to celebrate Mass for the soul of one who by any diabolical instigation hath voluntarily committed murder on himself, nor to commit his body to the ground with hymns and psalmody or any rights of honorable sepulture."²³ To this penalty, popular custom added the further punishment of dishonoring the corpse, which eventually became incorporated as part of the law.²⁴ This custom was a carryover from pagan practice²⁵ and reflected the air of superstition which hung over suicide.

17. O'Dea, *supra* note 13, at 257.

18. *Id.* at 258.

19. MOORE, FULL INQUIRY p. 307, (quoting PAENITENTIALE THEODORI ARCHIEP. CANTAU., (Paris ed., 1677)).

20. NORMAN ST. JOHN-STEVAS, LIFE DEATH AND THE LAW, 233 (1961); GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW, 257 (1972).

21. ST. JOHN-STEVAS, *supra* note 20, at 233; WILLIAMS, *supra* note 20, at 257.

22. O'DEA, *supra* note 13, at 131.

23. *Id.* at 311-312.

24. ST. JOHN-STEVAS, *supra* note 20, at 233.

25. WILLIAMS, *supra* note 20, at 258.

The first English legal treatise of consequence, known simply as Glanville, was published around 1187 and contains no mention of suicide.²⁶ Henry de Bracton's treatise, written between 1220 and 1260, largely incorporated the Roman law on suicide as presented in the Digest of the Emperor Justinian. Thus, Bracton charged that “[j]ust as a man may commit felony by slaying another so may he do so by slaying himself, the felony is said to be done to himself.”²⁷ If one is accused of a felony and “conscious of his crime and fearful of being hanged or of suffering some other punishment, he has killed himself; his inheritance will then be the escheat of his lords. It ought to be otherwise if he kills himself through madness or unwillingness to endure suffering.”²⁸ Elsewhere, Bracton introduced the innovation that the personal property of a suicide could be forfeit even if real property was not. Accordingly, one who killed himself in order to escape felony conviction lost his entire estate, but “if a man slays himself in weariness of life or because he is unwilling to endure further bodily pain . . . he may have a successor, but his movable goods are confiscated. He does not lose his inheritance, only his movable goods.”²⁹ Finally, Bracton provided that no penalty would attach to the suicide born out of insanity, for such persons could not commit felony de se.³⁰

The punishments inflicted upon the suicide were considerable. Properly speaking, of course, the suicide was beyond temporal jurisdiction, but his soul was subject to eternal damnation, his corpse became a target of indignity, and his survivors were met with embarrassment, ridicule and the specter of financial ruin. Saint Augustine warns that “no man ought to inflict on himself a voluntary death, thinking to escape temporal ills, lest he find himself among ills that are unending . . . inasmuch as the better life after death does not accept those who are guilty of their own death.”³¹ Thomas Aquinas argues further that “suicide is always

26. Marzen et al., *supra* note 6, at 57 (citing RANULF DE GLANVILLE, TREATISE ON THE LAWS AND CUSTOMS OF THE REALM OF ENGLAND, COMMONLY CALLED GLANVILLE (George Derek Gordon Hall ed., 1965)).

27. Marzen et al., *supra* note 6, at 58 (citing II HENRY DE BRACON, BRACON ON THE LAWS AND CUSTOMS OF ENGLAND 423 (George E. Woodbine ed. & Samuel E. Thorne trans., 1968)).

28. *Id.*

29. Marzen et al., *supra* note 6, at 59 (citing BRACON, *supra* note 27, at 423).

30. *Id.*

31. AUGUSTINE, I THE CITY OF GOD AGAINST THE PAGANS, § 26 at 113 (George E. McCracken trans., Harvard University Press 1957).

a mortal sin"³² and that the individual who intentionally repudiates the life which was given him by the Creator, displays the utmost disregard for the will and authority of his Master. Worse yet, the suicide commits this act of defiance in the very last moment of his life, leaving no time to expiate the sin through repentance. "Even the person who destroys a fellow creature does not renounce God to the same degree, 'for he kills only the body, whereas the self-murderer kills both the body and the soul.'"³³ The resulting Church pronouncement on self-slaughter was unwavering, "and so supreme was her power that the law of Christian Europe legalized her teachings."³⁴

As the result of ecclesiastical condemnations of self-ordained death "there came into existence the barbarous customs and the revolting indignities which were practiced upon the corpse of the suicide throughout the Middle Ages and which persisted until comparatively recently."³⁵ As Dublin and Bunzel provide:

The denial of Christian burial to the suicide was the Church's final weapon of prevention. Many curious customs grew up in the medieval Europe as a result of this prohibition. The corpse was treated with the greatest indignities. It was dragged through the streets by the feet, face downward and hung on the public gallows. Sometimes the heart was removed from the body; sometimes it was left in place, but a stake was driven through it as a mark of disrespect. Very frequently the body was not removed through the ordinary doorway of the house; either a special opening was made for it or it was dragged out through a window or through a perforation under the threshold. Possibly this was a hangover of primitive superstition which feared the re-entry into the house of a malevolent ghost.³⁶

32. THOMAS AQUINAS, SUMMA THEOLOGICA, 38 *Injustice* 33 (Marcus Lefébure trans., Blackfriars 1975).

33. LOUIS D. DUBLIN AND BESSIE BUNZEL, TO BE OR NOT TO BE 203 (1933).

34. *Id.*

35. *Id.*

36. *Id.* at 203-04. In England, the last suicide to be treated in this fashion was buried in June of 1823. *Id.* at 207. Accordingly, "[t]he body was wrapped in a winding sheet and brought out in a shell supported on the shoulders of four men. It was then wrapped in a piece of Russian matting, tied around with some cord and instantly dropped into a hold about five feet in depth. This was immediately filled up. No lime was thrown over the body; nor was a stake driven through the body. The following month a statute was passed legally abolishing this custom." *Id.* at 208 (citing R. Henslowe Wellington, *The Verdict 'Suicide whilst Temporarily Insane,'* in 1 TRANSACTIONS OF THE MEDICO-LEGAL SOCIETY 78 (1904)).

Despite the wanton cruelty inflicted upon the sane suicide, both the Church and the law were forgiving if the suicide were performed *non compos mentis*. "Traditional Christian theology has been developed on the basis that suicide, in general, is a perverse act of the will, and a conscious flouting of God's authority" and yet "[i]nsanity has always been considered to absolve from guilt."³⁷ Indeed, "Roman Catholic canon law provides that ecclesiastical penalties shall only apply if suicide is committed *deliberate consilio*."³⁸ Thus, compassionate clerics were tempted to presume insanity as the motive behind suicide in order to spare survivors the thought that their loved one was eternally damned as well as to avoid perpetuating the stigma of suicide through unsanctimonious burial. There is further evidence that juries were apt to make the same presumption in order to avoid inflicting undue hardship upon the families of suicides. In a sermon on the Sixth Commandment published in 1772, John Jortin ventured to declare what many people had been thinking. Since most suicides "have a disordered understanding":

In all dubious cases of this kind it is surely safer and better to judge too favorably than too severely of the deceased; and our Juries do well to incline, as they commonly do, on the merciful side, as far as reason can possibly permit; and the more so, since by the contrary verdict the family of the dead person may perhaps suffer much.³⁹

Richard Hey similarly noted that juries routinely evaded "the law 'rather than enforce a Punishment which *appears to them* so inequitable,—so severe upon the innocent,'"⁴⁰ while Blackstone reported "with disgust, that jurors behaved as if 'the very act of suicide is an evidence of insanity; as if every man who acts contrary to reason, had no reason at all.'"⁴¹ In 1728 the author of *Self-Murder* protested vehemently "against the over-frequent verdict of *non compos mentis* as resting on an illgrounded supposition that whoever is guilty of self-slaughter 'must of course be Lunatick' as '[t]he verdict nullified the effect of very desirable laws':

37. ST. JOHN-STEVAS, *supra* note 20, at 252-53.

38. *Id.* at 253 n. 1.

39. S.E. SPROTT V, THE ENGLISH DEBATE ON SUICIDE FROM DONNE TO HUME 140 (1961) (quoting JOHN JORTIN, SERMONS ON DIFFERENT SUBJECTS 145-48 (London 1772)).

40. *Id.* at 151 (quoting RICHARD HEY, A DISSERTATION ON SUICIDE (1785)).

41. SPROTT, *supra* note 39, at 157 (quoting 4 W. BLACKSTONE, COMMENTARIES 189 (1969)).

very wholesome, merciful, and prudent Laws, design'd to brand the Memory of the Self-Murtherer, to fix a Mark of Infamy upon him, and entail that Part of the Punishment, which he hath put himself out of the reach of, upon his unhappy Posterity, in order to deter others from the like inhuman and detestable Practices.⁴²

"In the eighteenth century juries increasingly brought in findings of insanity in order to save the family from the consequences of a verdict of felony; the number of deaths recorded as 'lunatic' grew startlingly in relation to the number recorded as self-murder."⁴³ As this general reaction to suicide became more deeply entrenched within society it strengthened further the underlying presupposition that whoever would take one's own life must necessarily be insane.

The assumption that suicide is *per se* grounds for a finding of insanity was supported by early medical and psychological opinion. O'Dea notes that the prevalent view of suicide during the nineteenth century was that one who destroys herself must be, *ipso facto*, emotionally unbalanced. Thus, he reports that in *Maladies Mentales*, Esquirol held that "no one attempts suicide unless during an attack of insane delirium"⁴⁴ while Falrèt "adopted the same conclusion, and asserted it even more emphatically than his predecessor."⁴⁵ Similarly, we are told that in *Du Suicide Considéré comme Maladie*, Bourdin "not only declared that [suicide] is always a malady, and that all suicides are insane, but saw in the

42. *Id.* at 121. A Discourse upon self-murder appeared in 1732 under an anonymous author. It is discussed in SPROTT, *Id.* at 119-121. Similarly, Caleb Fleming wrote that "[s]uicide is a crime that is so very shockingly DEFORMED, as not to have been discriminately noticed in any of the divine prohibitions; just as if it was not supposable, that an intelligent rational creature . . . could ever once admit the shocking idea, the unnatural, abhorrent image." *Id.* at 137 (quoting CALEB FLEMING, A DISSERTATION UPON THE UNNATURAL CRIME OF SELF-MURDER (1773)). As a remedy, Fleming proposes that "[o]ther measures should be taken to deter men from the unnatural, shocking crime of self-murder. —And I am humbly apprehensive, that a stop might be put to the spread of Suicidism, by having the naked body exposed in some public place: over which the coroner should deliver an oration on the foul impiety; and then the body, like that of the homicide, be given to the surgeons." *Id.* at 138.

43. *Id.* at 121.

44. O'DEA, *supra* note 13, at 258 (quoting JEAN ETTIENNE ESQUIROL, DES MALADIES MENTALES, CONSIDÉRÉES SOUS LES RAPPORTS MÉDICAUX, HYGIÉNIQUES ET MÉDICO-LEGAUX, 1838)).

45. *Id.* at 259 (quoting J.P. FALRET, DE L'HYPPOCHONDRIE ET DU SUICIDE, (1882)). For a concurrent synopsis of the works of Esquirol and Falrèt, see GEORGE ROSEN, *History, in A HANDBOOK FOR THE STUDY OF SUICIDE*, 3, 24-25 (Seymour Perlin ed., 1975).

very precautions taken by many suicides to ensure the successful execution of their purpose, unmistakable evidence of mental unsoundness.”⁴⁶ Thus, “[t]he phenomena preceding the accession [of the suicidal impulse] are constant; wherefore the sick prepare for some time before hand, arrange their affairs, write to their friends, choose the place where they shall die, artfully arrange every thing necessary to the accomplishment of their purpose, take every precaution to insure success.”⁴⁷ Then, after much to the same purpose Bourdin submits: “It is rare not to find evidence of mental trouble in the writings of which I have spoken; for even when the method of reasoning is sound, an exaltation of sentiment is perceptible, a warmth of soul which borders on passion.”⁴⁸

O’Dea writes in rejoinder that “[a]n ‘exaltation of sentiment’ and ‘warmth of soul’ bordering on passion, are certainly not evidences of insanity.”⁴⁹ Moreover, making a point of Bourdin, O’Dea casts suspicion upon the logical rigor of arguments which seek to prove that *all* suicides are necessarily insane: “He said suicide is an insane act because the deeds that precede it must be of an insane character. And he demonstrated this proposition by showing that the deeds are of an insane character because suicide in an insane act.”⁵⁰

A deeper investigation of the predominate psychological prejudice reveals that the alleged nexus between insanity and suicide is founded upon a still wider assumption. The instinct for self-preservation is one of humankind’s strongest proclivities. It is therefore supposed that by virtue of this instinct every sane person must shun death. “But it will hardly be necessary to insist that, however strong the instinct of self-preservation may be—and no one denies its strength—it is not a reliable test for distinguishing between the sane and the insane.”⁵¹ After all, O’Dea notes, a number of counterarguments may be given: “The instinct of self-preservation is not so strong as to keep men from exposing themselves to all but sure death in some forlorn-hope on the field of battle, or even to sure death, as when they surrender themselves for execution in some cause, religious, political, or what not,

46. O’DEA, *supra* note 13, at 259 (quoting M. BOURDIN, *DU SUICIDE CONSIDÉRÉ COMME MALADIE* (Paris 1845)).

47. O’DEA, *supra* note 13, at 259.

48. *Id.*

49. *Id.*

50. *Id.* at 260.

51. *Id.*

in which they take an absorbing interest."⁵² Furthermore, the "instinct of self-preservation, moreover, is preservative against pain as well as death; but how numerous the examples of pain—agonizing pain even—endured in some cause, in support of some principle dear to the sufferer!"⁵³

The belief that no sane person would kill herself lingers today. Yet, despite the historical association between suicide and insanity, there is simply no convincing argument which shows that suicide is *per se proof* of insanity. Particular acts of suicide may be precipitous or even rash, and under a variety of circumstances one might legitimately infer a connection between instances of self-destruction and some underlying mental illness. But there is no way to show that *all* decisions to die result from a disturbed psyche. When life's value has been spent, leaving only misery and frustration in its wake, and the fully reflective self-sovereign individual sees no glimmer of hope or meaning in continued existence, a decision to die may well prove the mark of a sane and rational person.

But, granted that an examination of historical attitudes towards self-destruction expostulates that the formula equating suicide with an act of insanity is ill-founded, is there not sufficient current medical evidence to suggest, at least, a correlation between mental illness and the suicidal impulse? Is it not the case that many persons who wish to die suffer from some underlying emotional perturbation? Furthermore, isn't insanity a matter of degree?—how deranged must an individual be before the state is warranted in "protecting him from himself?"

LEGAL COMPETENCE

The law recognizes that "insanity differs in kind and character, as well as in degree"⁵⁴ and that accordingly, "it is not subject to a precise definition applicable to all situations."⁵⁵ As a rule, however, "insanity denotes that condition of mind which is so impaired in function, or so deranged, as to induce a deviation from normal conduct in the person so afflicted. More particularly, it denotes a mind that is unsound, deranged, delirious, or distracted."⁵⁶ Insanity is defined as:

52. *Id.*

53. *Id.* at 260-61.

54. 41 AM. JUR. 2D *Incompetent Persons* § 1 (1968).

55. *Id.*

56. *Id.*

a social and legal term rather than a medical one, and indicates a condition which renders the affected person unfit to enjoy liberty of action because of the unreliability of his behavior with concomitant danger to himself and others. The term is more or less synonymous with mental illness or psychosis . . . [and] is used to denote that degree of mental illness which negates the individual's legal responsibility or capacity.⁵⁷

While the test for competency applied in a particular situation or proceeding "is governed to a great extent by the nature of that proceeding and the statutes applicable thereto,"⁵⁸ in general, the test is determined by the "capacity to understand and appreciate the nature of the particular act and to exercise intelligence in its performance."⁵⁹ Furthermore, "[s]oundness of mind depends on the general frame and habit of the mind, and not on specific actions, such as may be reflected by eccentricities, prejudices, or the holding of particular beliefs. Eccentricity is not the equivalent of insanity, however peculiar it may appear."⁶⁰

It has been observed that "Anglo-American law starts with the premise of thorough-going self-determination"⁶¹ and that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person."⁶² The "right to one's person may be said to be a right of complete immunity: to be let alone."⁶³ As conceptualized by Justice Brandeis:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.⁶⁴

57. BLACK'S LAW DICTIONARY 794 (6th ed. 1990).

58. 41 AM. JUR. 2D *Incompetent Persons* § 1 (1968).

59. BLACK'S LAW DICTIONARY 795 (6th ed. 1990).

60. 41 AM. JUR. 2D *Incompetent Persons* § 6 (1968).

61. Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960).

62. Union Pacific R. C. v. Botsford, 141 U.S. 250, 251 (1891).

63. *Id.*

64. Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

Moreover, the Constitution's commitment to personal autonomy includes the right of the individual to make decisions regarding his own welfare even if such choices appear unwise or even foolhardy to others. Thus, explicating Brandeis' immortal pronouncement regarding the "right to be let alone," Warren Burger wrote: "Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk."⁶⁵

The irrationality of a patient's decision does not justify a conclusion that the actor's capacity to make the decision was impaired to the point of legal incompetence. Thus, the principle question for review in *Lane v. Candura*⁶⁶ was whether a 77-year-old patient suffering from gangrene in the right foot and lower leg who refused to permit a necessary lifesaving operation possessed "the legally requisite competence of mind and will to make the choice for herself."⁶⁷ The patient had originally agreed to amputation of the leg but then withdrew consent on the morning scheduled for the operation. She was discharged from the hospital but returned a few days later. Responding to the persuasion of a doctor, the patient again consented to the operation soon thereafter reiterated her refusal. The rationale for her decision included the factors that she had been unhappy since the loss of her husband; she did not wish to burden her children; she did not believe the operation would cure her; she did not want to live as an invalid or in a nursing home; and that she did not fear death but welcomed it. The testimony presented to the lower court suggested that the patient was "lucid on some matters and confused on others."⁶⁸ Her train of thought would occasionally wander and her conception of time was distorted. She was hostile to certain doctors, and was sometimes defensive or even combative in her response to questioning. Although one of two psychiatrists who testified at trial stated that the patient was "incompetent to make a rational choice whether to consent to the operation,"⁶⁹ the appellate court

65. *In re President and Directors of Georgetown College, Inc.*, 331 F. 2d 1010, 1117 (D.C. Cir. 1964), *cert. denied*, 337 U.S. 978 (1964) (Burger, J., dissenting).

66. *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978).

67. *Id.* at 1233.

68. *Id.* at 1234.

69. *Id.* at 1235.

was careful to distinguish a medically *rational* choice from a decision lacking the requisite mental competence:

[T]he irrationality of her decision, does not justify a conclusion that Mrs. Candura is incompetent in the legal sense. The law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.

....
Mrs. Candura's decision may be regarded by most as unfortunate, but on the record in this case it is not the uninformed decision of a person incapable of appreciating the nature and consequence of her act. We cannot anticipate whether she will reconsider and will consent to the operation, but we are all of the opinion that the operation may not be forced on her against her will.⁷⁰

Similarly, in *In re Quackenbush*,⁷¹ a 72-year-old patient suffering from arteriosclerosis and gangrene in both legs refused to consent to a necessary amputation. The patient was initially advised to have surgery but refused. Approximately two months later the patient was hospitalized and signed a form consenting to the operation. Later that same day the patient withdrew consent. As such, the hospital petitioned for the appointment of a guardian to consent on the patient's behalf. Testimony concerning the patient's mental condition was elicited from two psychiatrists. The psychiatrist representing the hospital concluded that the patient's mental condition was not sufficient to make an informed decision regarding the operation. In the words of the court:

The doctor's conclusions are that Quackenbush is suffering from an organic brain syndrome with psychotic elements. He asserts that the organic brain syndrome is acute—i.e., subject to change—and could be induced by the septicemia. He bases his opinion on the patient's disorientation as to place—not aware of being in a hospital; his disorientation as to the people around him—not aware of talking to a nurse and doctor during the interview; his visual hallucinations—seeing but not hearing people in the room who are not there, and the inappropriateness of his responses to the discussion on the gravity of his condition and what might result.⁷²

70. *Id.* at 1235-36 (citations omitted).

71. *In re Quackenbush*, 383 A.2d 785 (N.J. Super. Ct. 1978).

72. *Id.* at 788.

A specialist in geriatric psychiatry testifying as an independent witness concluded, however, that despite "fluctuations in mental lucidity"⁷³ the patient was capable of informed consent:

Quackenbush has the mental capacity to make decisions, to understand the nature and extent of his physical condition, to understand the nature and extent of the operations, to understand the risks involved if he consents to the operation, and to understand the risks involved if he refuses the operation.⁷⁴

The court agreed with the latter testimony, writing that "Quackenbush is competent and capable of exercising informed consent on whether or not to have the operation."⁷⁵ Despite elements of psychosis, occasional hallucinations, general disorientation and waning lucidity, the patient was sufficiently cognizant as to comprehend the nature and consequences of his decision. Accordingly, *Quackenbush* underscores the general rule of law that mental competence is determined by the patient's "capacity to understand and appreciate the nature of the particular act and to exercise intelligence in its performance."⁷⁶ Competence is *not* gauged by *specific actions*,⁷⁷ eccentricities, or the patient's personal predilections; nor is competence judged according to whether a particular course of action is considered rational or prudent by third persons.

REASONABLE DECISIONS TO DIE

Recent years have evinced mounting interest in the questions of self-directed death, the active and direct disemployment of life-support, and physician-assisted suicide. In an effort to combat the judicial recognition of a constitutional right to choose to die, Marzen, O'Dowd, Crone, and Balch have gone to considerable lengths to argue that "the vast majority of modern courts have conceived of the person who would commit suicide as neither a moral reprobate nor a heroic practitioner of a civil liberty, but as mentally or emotionally deranged or unbalanced"⁷⁸ and that "this presumption is strongly supported by the psychiatric, psychologi-

73. *Id.*

74. *Id.*

75. *Id.*

76. BLACK'S LAW DICTIONARY 795 (6th ed. 1990).

77. 41 AM. JUR. 2D *Incompetent Persons* § 6 (1968). It appears that a decision to die, by itself, would not properly constitute grounds for a finding of insanity.

78. Marzen et al., *supra* note 6, at 105.

cal, and sociological literature on suicide."⁷⁹ The authors further assert that "[i]f it exists[s] at all, 'rational' suicide is rare,"⁸⁰ as "almost all who commit suicide suffer from some mental disorder."⁸¹ But it does not require any great mental acuity to bring quickly to mind numerous circumstances in which a decision to die would prove to be not only the deliberate and competent act of a sane person, but also the most optimally rational act in light of the individual's aspirations and ends.

Consider, for example, the plight of Ken Harrison in Brian Clark's drama, *Whose Life Is It Anyway?*⁸² Harrison is a creative and intelligent sculptor in his late twenties who, upon carefully considering the prognosis that his paralysis from the neck down is incurable, announces that he would prefer to die rather than spend his remaining forty to fifty years confined to a hospital bed. Because he is physically incapable of destroying himself, and euthanasia is forbidden by law, Harrison's only hope is to demand release from the hospital to be sent home where, without a catheter, he will perish of his own blood toxins. Although he has deliberated calmly and continually over the matter for six months, the hospital refuses the request, and Harrison's continued protestations are lost in a maze of "no-win" scenarios. After all, because of the psychiatric assumption that decisions to die are indicative of mental illness, if an individual makes such a request, the request itself proves mental instability and must accordingly be denied.

At one point, Harrison complains that one of the justifications for refusing his request is a version of Catch-22. The term "Catch-22" originated with Joseph Heller's novel of that name in which it is used characteristically for a particular type of military rule that places the petitioner in an inescapable dilemma, in effect barring his petition *a priori* in language that falsely suggests that there are conditions under which the plea could be granted, when in fact those "conditions" are contradictory.⁸³ Feinberg adopts this terminology to suggest that "there are as many as four Catch-22 arguments in *Whose Life Is It Anyway?* that beg the question against

79. *Id.*

80. *Id.* at 107.

81. *Id.* at 142.

82. JOEL FEINBERG, HARM TO SELF (1986) (explaining *Whose Life Is It Anyway? A Play by Brian Clark* (1978)).

83. FEINBERG, *supra* note 82 (describing JOSEPH HELLER, CATCH-22 (1961)).

Mr. Harrison and make it *a priori* impossible for him to prove the voluntariness of his request.”⁸⁴

The first Catch-22 argument concerns the question whether Harrison’s acknowledged clinical depression is sufficiently profound as to impair judgment. Dr. Emerson believes the answer self-evident: “You haven’t understood . . . He’s *suicidal*. He’s determined to kill himself.”⁸⁵ As Feinberg explains:

The assumption apparently is that if a depressed person requests to die that *proves* that his depression impairs judgment, and his request therefore is insufficiently voluntary to be granted. This argument suggests that only persons who are happy are capable of voluntarily choosing suicide, and of course they are precisely the ones who won’t apply. Thus if you are unhappy you *cannot* voluntarily choose suicide, and if you are happy you *will not* commit suicide. The conclusion: no suicide.⁸⁶

The second Catch-22 argument closely resembles the first and is similarly concerned with the voluntariness of Harrison’s decision. In pertinent part, Dr. Scott reminds Emerson that “It’s *his* [Harrison’s] life.”⁸⁷ To which Emerson replies, “But my responsibility.”⁸⁸ Scott rejoins, “Only if he is incapable of making his own decision.”⁸⁹ “But he isn’t capable,” insists Emerson—“I refuse to believe that a man with a mind as quick as his, a man with enormous mental resources, would calmly choose suicide.”⁹⁰ Scott replies, “But he has done just that.”⁹¹ “And therefore,” interjects Emerson, “I say he is unbalanced.”⁹² Again the question is decided in advance against the petitioner. Feinberg explains that under this scenario Harrison’s request

cannot possibly be voluntary, not because it fails to satisfy independent formal tests of voluntariness, but entirely because of what it is a request for . . . [To determine] that no death request, simply as such, *could be* valid is to apply a circular test. This approach is very much like that of a college which, when interviewing applicants for admission, rules out those who apply on the

84. FEINBERG, *supra* note 82, at 359.

85. *Id.*

86. *Id.* at 359-60.

87. *Id.* at 360.

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

ground that anybody who could apply for admission here *must* be unbalanced.' "⁹³

As a corollary of the preceding, the third Catch-22 argument occurs when the hospital staff psychiatrist warns Harrison that his obvious intelligence weakens his case: "I'm not saying that you would find life easy, but you do have resources that an unintelligent person doesn't have."⁹⁴ This observation prompts Harrison's analogy to Catch-22: "If you're clever and sane enough to put up an invincible case for suicide, it demonstrates that you ought not to die."⁹⁵ The reference to Catch-22 is apropos. Harrison must construct a convincing argument for suicide or else the authorities will not grant his petition. But anyone clever enough to argue such a position is precisely the type of individual who ought not be permitted to die since his mental acumen provides him with resources beyond those of the average person in kindred circumstances. In either event, Harrison will not be permitted to die.

The final Catch-22 argument is issued by Dr. Scott when she senses Harrison's excitement at the approach of his judicial hearing. "I think you are enjoying all this,"⁹⁶ she says. "I suppose I am in a way," Harrison replies, "for the first time in six months I feel like a human being again."⁹⁷ This exchange emphasizes the paradox: Harrison is never so much alive as when he is fighting for death. But to make too much of this point is to impale the petitioner on the horns of a dilemma: "If he enjoys getting what he wants (permission to die), then he is not depressed and has less reason to die, but if he is not pleased at his victory then he must not really have wanted to die after all, and that casts doubt on the authenticity of his prior desire. Either he is pleased or he is not pleased. Therefore, he must not be permitted to die."⁹⁸

The general predicament faced by the hypothetical Ken Harrison has already been mirrored in reality.⁹⁹ For many seriously

93. FEINBERG, *supra* note 82, at 360.

94. *Id.*

95. *Id.*

96. *Id.* at 361.

97. *Id.*

98. *Id.*

99. See *Bouvia v. Superior Court* (Glenschur), 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990). See generally *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452 (D.D.C. 1985); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Ct. App. 1980), *aff'd*,

ill competent adults—especially those facing irreversibly degenerative diseases—continued existence may well prove worse than death. It is agreed on all hands that incompetents should be restrained from unwarranted acts of self-destruction. But if the bold desire to die presents *prima facie* evidence of insanity, then any impulse toward death would prove itself symptomatic of mental illness. Thus, the argument proceeds, that suicide must never be allowed because most, if not all, suicides are the result of insanity. But the evidence of insanity consists—at least in part—upon the *presumption* that no sane person would want to kill herself.

Thus, as we have seen, Marzen, O'Dowd, Crone, and Balch suggest that suicide is *prima facie* evidence of mental instability and that “this presumption is strongly supported by the . . . literature on suicide.”¹⁰⁰ Although the authors amass a considerable compendium of literature designed to illustrate the rationale for their psychological predilections regarding self-destruction, this does not entirely avert the Catch-22 quality of the argument which seems to establish *a priori* the aberrant nature of suicide.

In pertinent part, for example, the authors roundly declare that “ninety-four percent (94%) of the population that commits suicide suffers from mental disorder, although wide variations exist in the type of disorder. The most commonly cited disorders are the depressive affective disorders.”¹⁰¹ While “[s]ome critics regard the affective disorder as part of a normal or rational mental condition,”¹⁰² the authors maintain that the very definition of affective disorder bars this conclusion:

“The essential feature of this group of disorders is a disturbance of mood . . . that is not due to any other physical or mental disorder. *Mood* refers to a prolonged emotion that *colors the whole psychic life*; it generally involves either depression or elation.” Thus, in applying the term ‘affective disorder’ one assesses not the validity of a feeling, but rather the degree to which a certain mood misrepresents (or suppresses) the rest of the psychic life, including the

379 So. 2d 359 (Fla. 1980); *In re Lydia E. Hall Hosp.*, 455 N.Y.S.2d 706 (1982); *In re Farrel*, 529 A.2d 404 (N.J. 1987).

100. Marzen et al. *supra* note 6, at 105.

101. *Id.* at 112-13.

102. *Id.* at 113 (referring to Thomas Szasz, *The Ethics of Suicide*, 31 ANTIOCH REV. 7 (1971)).

person's emotions, values, and thinking capacities at the time of the suicide.¹⁰³

Moreover, we are informed that the "psychotically depressed are particularly high risk candidates relative to other depressives, but they are by no means the only group at risk. Affective disorders, of which suicidal behavior (acts, attempts, threats or thoughts) is a universally recognized manifestation, include major depressive disorders, dysthymic disorder, bipolar disorder and depressive episode."¹⁰⁴ Furthermore, the "bulk of research indicates that just under half of the individuals who kill themselves have well characterized depressive disorders. Further evidence suggests that while most suicidal individuals would not be diagnosed as having an affective disorder, most are nonetheless depressed."¹⁰⁵ "Depression [itself] is an objectively verifiable and diagnosable entity and . . . its designation as an illness or disorder is not purely arbitrary."¹⁰⁶ Indeed, "psychologists view depression not only as a perceptual or motor impairment, but also as a decrease in optimal cognition. A depressive disorder is distressing not only due to the dysphoric mood which characterizes it, but also because it may significantly impair the cognitive function."¹⁰⁷

Presumably, the authors would agree that depressed persons should never be permitted to facilitate their own death because they suffer from a "mental disorder"—"a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that typically is associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability)."¹⁰⁸ Yet their treatment of the question

103. *Id.* (quoting AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 205 (3d ed. 1980)).

104. Marzen et al., *supra* note 6, at 114 (quoting MODERN SYNOPSIS OF COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 362 (Harold I. Kaplan & Benjamin J. Saddock, eds., 4th ed. 1983) and AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 207, 210-211, 216, 221-223 (3d ed. 1980)).

105. *Id.* at 115 (quoting ELI ROBBINS, THE FINAL MONTHS: A STUDY OF THE LIVES OF 134 PERSON WHO COMMITTED SUICIDE 12 (1901)).

106. *Id.* at 116, (referring to AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 205 (3d ed. 1980)).

107. *Id.* at 117 (citing TEXTBOOK OF PSYCHIATRY, *supra* note 104, at 356 (1983) and BECK, THINKING AND DEPRESSION, 9 ARCHIVES GEN. PSYCHIATRY 324, 326 (1963)).

108. Marzen et al., *supra* note 6, at 111 (quoting AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 56 (3d ed. 1980)).

of mental disorder in suicides is curious. The authors present a crowded potpourri of psychological items linking various forms of mental instability with the suicidal impulse and group a number of disparate emotional aberrations together under the general heading "depressive disorders" in an effort to show that suicide is almost always the result of a clouded psyche. This classificatory maneuver may prove less problematic if we allow that "individuals with other mental disorders display some or all of the characteristics of depressive disorder, including but not limited to suicidal activity" and "are no less disabled by these symptoms than is one with an affective disorder."¹⁰⁹ Moreover, even if "most suicidal individuals would not be diagnosed as having an affective disorder, most are nonetheless depressed,"¹¹⁰ and depression engenders "cognitive distortions that may affect choices and behavior to a significant degree."¹¹¹ But of greater concern than the authors' tendency to blur the subtle yet important distinctions between the various types of "mental disorders" is their failure to examine—in any degree of earnestness—the extra-psychological reason or precipitating circumstance under which a person might become justifiably depressed. As Feinberg provides, some depression is understandable,

even proper, rational, and justifiable, a state of mind any normal person would experience if he were to suffer certain losses. 'Depression' is also the name of a clinical syndrome marked by 'affective disorders,' involving 'an accentuation in the intensity or duration of otherwise normal emotions.' Psychologists have not agreed on any simple criterion for distinguishing accentuated affective states that are 'clinical' from those that are less extreme or less debilitating conditions, but they often speak of a plurality of symptoms, at least some of which are present in clinical depression, in addition to the depressed or 'dysphoric' mood (sadness, gloominess) that is common to both the clinical and nonclinical species . . . If clinical depression is determined by the presence of one or more of such symptoms in high degree, quite independently of their cause or occasion, then it cannot be sharply contrasted with that 'understandable depression' which is a 'perfectly rational reaction to a very bad situation.' . . . And even if understandable depression is also clinical depression, it need not involve

109. *Id.* at 115.

110. *Id.* (citing ROBBINS, *supra* note 105, at 12).

111. *Id.* at 120 (citing Silverman, Silverman, and Eardley, DO MALADAPTIVE ATTITUDES CAUSE DEPRESSION? 41 ARCHIVES GEN. PSYCHIATRY 28, 29 (1984)).

any distortion of cognitive function. To be sure, *some* clinical depressives are also ‘psychotic’ (i.e., crazy), but most are not.¹¹²

Thus, for pertinent example, when Ken Harrison learns that he will never leave his hospital bed under his own volition, he becomes *understandably* depressed. Indeed, any sane and rational person beset by similar circumstances *ought* to be depressed, and one would have grounds to suspect emotional instability in a patient similarly situated who did *not* respond with symptoms of depression. Nevertheless, armed with a battery of presumptions equating decisions to die with mental instability, Dr. Emerson refuses even to consider Harrison’s request, stating in relevant part that Harrison is suffering from a depression and is therefore “incapable of making a rational decision about life and death.”¹¹³ In a subsequent judicial hearing, Emerson testifies that under the circumstances “depression and the tendency to make wrong decisions goes on for months, even years.”¹¹⁴ Yet under cross examination, he is forced to admit that there are no objective tests by which to distinguish a medical syndrome from a perfectly sane and legitimate reaction of depression and that he must rely simply upon his many years of experience in order to formulate such a judgment. The consulting psychiatrist selected by Harrison’s attorney does not dispute Harrison’s depression but testifies that the patient’s attitude is not merely an outcropping of clinical depression but rather that “he is reacting in a perfectly rational way to a very bad situation.”¹¹⁵ More pointedly, in response to the diagnosis of “acute depression,” Harrison himself responds: “Is that surprising? I am almost totally paralyzed. I’d be insane if I *weren’t* depressed.”¹¹⁶

In such extreme cases, there can be no doubt that reactive clinical depression *can* distort the patient’s judgment. But this is not to say that it must do so, or that the depression involved impairs cognitive function to the point of incompetence. Precisely because some depression is quite reasonable and expected in light of personal catastrophe, questions of competent judgment must be decided on a case-by-base basis. To flatly assume that depression, clinical or otherwise, necessarily imperils competence is unfair to

112. FEINBERG, *supra* note 82, at 355.

113. *Id.* at 352.

114. *Id.* at 352-53.

115. *Id.* at 353.

116. *Id.* at 355.

the patient as it effectively deprives her, on *a priori* grounds, of any opportunity to establish her case.

In fine, the approach taken by Marzen, O'Dowd, Crone, and Balch seems to dangerously parallel the argument(s) advanced by Dr. Emerson in *Whose Life Is It Anyway?* by effectively "stacking the deck" against any patient who would pursue a direct and active means of hastening death. The authors establish as a rule the presupposition that suicide *per se* is *prima facie* indicative of mental instability and thereupon amass a copious armory of psychological literature associating suicide with various forms of insanity. But because the ensuing presentation is devoid of any *real* mention of extra-psychological precipitating circumstances, the question is actually decided well in advance of any purported "argument": If the patient wants to die and is agitated or depressed, then he must be suffering from one of the many "mental disorders" associated with the suicidal impulse or at least possesses "cognitive distortions" which may impair his judgment. But if the patient is not depressed to a significant degree, then he is not likely to request the disemployment of life-support or other lethal remedy, as his particular assessment of present and future possibilities reveals to him that his life is worth living even under such circumstances. In either event: no suicide.¹¹⁷

The question under such circumstances should never hinge upon such considerations as whether or not the patient suffers from a possible "decrease in optimal cognition." Rather, the point of inquiry should focus upon *mental competence*: the capacity to understand and appreciate the nature of the particular decision and its consequences.¹¹⁸ Furthermore:

[C]ompetence should be defined by courts in a way that does not deprive the potential suicide of the right to choose. It must be defined with a view to securing for the subject the right to choose to die despite the wishes of doctors, friends, psychologists, and

117. Under such premises one might further assume that since decisions to die evince insanity, then anyone who is *not* depressed and nevertheless wants to die is, *ipso facto*, insane.

It is worth emphasizing that the authors do not limit their attention to so-called "depressive disorders" but rather seek to associate a broad spectrum of emotional abnormalities with thoughts of suicide. The notion of "depression," however, is particularly interesting within the context of decisions to terminate artificial life-support, as one would naturally expect that someone weighing such a choice would be depressed.

118. *In re Quackenbush*, 383 A.2d 785 (N.J. Super. Ct. 1978); *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978).

judges. The test of competence should inquire whether the subject has the mental capacity to comprehend his predicament and to evaluate the alternatives. Furthermore, competence should be presumed; the presumption should be rebutted only by convincing evidence of coercion, mental instability, or ignorance.¹¹⁹

The weight of the many right-to-die decisions handed down thus far evince that the courts seek no higher standard of mental acumen, as the basic constitutional freedom "to be let alone" is not limited to "sensible beliefs, valid thoughts, reasonable emotions, or well-founded sensations" but includes "a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk."¹²⁰ If an individual is competent, then the state is not warranted in usurping the powers within his self-sovereign domain even if his choice of alternatives does not appear optimally judicious to others.

There is no doubt that some decisions to die are the products of insanity and persons so afflicted ought to be restrained from unwarranted acts of self-destruction. But to suggest that a bare decision to die—considered apart from any examination of attendant circumstances—is itself *prima facie* indicative of mental instability is grossly unfair to the patient as it places a nearly insurmountable burden of proof upon him. How readily could any so-called "normal" person successfully overcome a presumption of

119. Alan Sullivan, *A Constitutional Right to Suicide*, in *SUICIDE: THE PHILOSOPHICAL ISSUES* 229, 245 (M. Pabst Battin & David J. Mayo, eds., 1980). Sullivan continues:

although competence must be presumed, the weight accorded that presumption must vary from case to case. The courts must look not only to the testimony of persons who know the subject, but they must also pay attention to his objective circumstances: his age, his illness, and his prospects. As the subject's prognosis dims, the presumption of his competence must be entitled to greater weight. Insofar as the subject is shown to have viable alternatives to suicide, however, his presumed competence must be examined with greater care. Few would question the competence of a person's decision to die if he is old and suffers from a painful, incurable illness. But if a person is young and healthy and wishes to end his life, his competence must be scrutinized more closely. This is not to say that courts should substitute their own choice for that of the person who wishes to die. Rather, courts should apply a flexible standard of competence to avoid the tragic results of insanity or ignorance. The court's objective in both instances should be to protect the right to choose by insuring the subject's ability to choose.

Id.

120. *In re President and Directors of Georgetown College, Inc.*, 331 F. 2d 1000, 1017 (D.C. Cir. 1964), *cert. denied*, 337 U.S. 978 (Burger, J., dissenting).

insanity in order to prove that he was, in fact, *sane*? The presumption that self-willed death is exemplary of madness also works in derogation of the common law rule that “[a] person is presumed to be competent unless shown by the evidence not to be competent.”¹²¹ The alleged irrationality of a particular decision—even a decision to die—will not in itself justify a conclusion that the actor is legally incompetent.¹²² Moreover, many decisions to die not only prove to be the sane act of a competent person but illustrate an optimally rational decision in light of an individual’s aspirations and ends. As Richards argues consistently, the concept of rationality ought to take “as its fundamental datum the agent’s ends and aspirations, which the agent organizes, evaluates, and revises dispassionately in terms of standards and arguments to which she or he assents as a free and rational being. In this context, principles of rational choice are those standards which call for the assessment of choices in terms of the degree to which alternative choices better satisfy the person’s ends and aspirations over time.”¹²³ Accordingly, “[e]ven outside such contexts as terminal illness, present death may be a reasonable course for persons who find in continued life the frustration of all the significant aims and projects in which, as persons with freedom and full rationality, they define their selves and in which the choice of death may, as an expression of dignified self-determination, better realize their ideals of living than a senseless life of self-contempt.”¹²⁴ Under this line of reasoning, many persons would concur that Ken Harrison’s decision to die was not only the deliberate act of a sane man but also a reasonable decision in light of Harrison’s predicament and particular assessment of a “life worth living.” Similarly, numerous courts have agreed that specific decisions to die may be competently decided as well as under-

121. *Lane v. Candura*, 376 N.E.2d 1232, 1235 (Mass. App. Ct. 1978). See also *Howe v. Howe*, 99 Mass. 88 (1868); *Wright v. Wright*, 29 N.E. 380 (Mass. 1885).

122. *Lane*, 376 N.E.2d at 1235. See also 41 AM. JUR. 2D *Incompetent Persons* § 6 (1968).

123. David A.J. Richards, *Constitutional Privacy, The Right to Die and the Meaning of Life: A Moral Analysis*, 22 WM. AND MARY L. REV. 327, 392 (1981). Similarly, “rationality must be defined relative to the person’s system of ends which, in turn, are determined by the person’s appetites, desires, capacities, and aspirations. Principles of rational choice require the most coherent and satisfying plan for accommodating the person’s projects over time.” *Id.* at 369.

124. *Id.* at 360.

standable under the circumstances.¹²⁵ But regardless of whether third persons *approve* of a patient's decision, if he is competent, it is his choice alone to make. "Why should a person be permitted to implement a 'wrong' or 'unreasonable' decision to die? The only answer possible is simply that it is *his* decision and *his* life, and that the choice falls within the domain of *his* morally inviolate personal sovereignty."¹²⁶ While it is clearly an indignity to destroy others against their will, it is equally an indignity to force a competent adult to remain alive against his will. "Human dignity is not possible without the acknowledgement of personal sovereignty."¹²⁷

125. *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); *Bouvia v. Superior Court (Glenchur)*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986), *State v. McAfee*, 385 S.E.2d 651 (1989); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990).

126. FEINBERG, *supra* note 82, at 361.

127. *Id.* at 354.